Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

www.dmas.virginia.gov

MEDICAID MEMO

TO: All Providers of Maternal Infant Care Coordination (MICC) services participating in the Virginia Medical Assistance Programs, including Health Department Clinics, Federally Qualified Health Centers, Rural Health Clinics, Department of Social Service, Case Management Providers, Private Home Health Agencies and Community Service Boards.

High risk maternity and infant program managers of the Medicaid Managed Care Organizations (MCOs).

FROM: Patrick W. Finnerty, Director
Department of Medical Assistance Services (DMAS)

MEMO Special
DATE 7/14/2006

SUBJECT: BabyCare Covered Service Changes and mileage rate increase.

The purpose of this memorandum is to notify Medicaid providers of the changes affecting the BabyCare program, including Maternal Infant Care Coordination (MICC) services and Expanded Prenatal Services. A chart describing the changes is provided at the end of this Memorandum.

DESCRIPTION OF MICC SERVICES

High risk pregnant women and infants, up to age two, who are Medicaid Fee for Service (FFS), FAMIS FFS, or FAMIS MOMS eligible, may be enrolled in the MICC program to receive a variety of services to ensure positive birth outcomes. MICC providers may include Health Department Clinics, Federally Qualified Health Centers, Rural Health Clinics, Department of Social Services, Case Management Providers, Private Home Health Agencies, and Community Service Boards. Medicaid Managed Care Organizations (MCOs) have their own high risk maternity and infant programs that offer services comparable to DMAS MICC.

CHANGES TO MICC REQUIREMENTS

DMAS has changed the requirements and timeframes for contacts with clients in the MICC program. These changes, listed below, will be included in a future BabyCare Manual update:

1. Initial Contact for Assessment and Enrollment: The requirement that a face-to-face visit be made to the client within 10 days of the receipt of referral has been adjusted for situations when the client may be more difficult to engage in services. While a

face-to-face contact should be scheduled as soon as possible, the new requirement is for a collateral contact to be made, at a minimum, within 15 calendar days of the receipt of referral. A collateral contact is defined as contact via telephone to the client, primary care provider and/or family members in an effort to begin MICC services. The client is considered open to MICC once the care coordinator initiates the first contact (either collateral or face-to-face). This date is to be documented in section 21 on the DMAS-50 form (MICC Record).

2. Face-To-Face Contact: A face-to-face contact must occur with the client within 30 calendar days from the receipt of the referral.

3. Extension for Visits: In the event that the care coordinator cannot make the face-to-face contact within 30 days of receipt of referral, an extension of 30 days will be granted to allow the care coordinator to continue contacting the client to start services. The care coordinator must document the reason the face-to-face contact did not occur within the first 30 day period. If after this 30 day extension the care coordinator is not able to complete the face-to-face contact, the client's case must be closed and the care coordinator must notify the primary care provider and the client via letter that the case will be closed. At this time, the care coordinator would send DMAS a copy of the completed risk screen (DMAS 16 or 17) and the MICC record (DMAS-50), with the client demographic portion and sections #21 and #81 completed.

4. Initial Contact Billing Requirements: In order to bill DMAS for initial monthly care coordination when the face-to-face contact with the client is not successful and documented, the care coordinator must have documented collateral contacts (successful and/or attempted) with the primary care provider and family members of the client. This is to ensure that a good faith effort has been made to engage the client in services. All contacts attempted, collateral and face-to-face, with the client, family and primary care provider, must be documented in the medical record.

5. Refusal of Enrollment: If the maternal client or infant's family decide at any point during the assessment process not to enroll, DMAS will reimburse the MICC provider for the assessment visit. The MICC provider must check block #82 on the DMAS-50 to indicate that the client refused services, and complete the demographic portion as well as section #81. The provider must submit the DMAS-50 and completed Risk Screen to the Agency.

6. Although the MICC provider may bill DMAS for care coordination beginning with the date of the initial collateral contact, mileage may not be billed until a successful face-to-face visit with the client is completed.

7. Follow-Up Monthly Contacts/Requirement for Billing: After the client begins to receive MICC services, the visits (either collateral or face-to-face) must be at least monthly for both maternal and infant MICC clients. The visit schedule should meet

the needs of the client, which are identified in the service plan. The level of involvement will vary among clients due to the level of need, identified risks, availability of providers/services within the area, the support available to the client and the client's ability to follow the service plan.

Monthly care coordination may be billed to DMAS if successful face-to-face or telephonic contact with the maternal client or infant client's parent/caregiver is completed and documented.

In the event that the care coordinator cannot establish contact during a given month after a client has been open to MICC, an extension of one additional month will be granted to allow the care coordinator to continue contacting the client to resume services. The care coordinator must document the reason the contacts with the client did not occur within the given month as well as document the contacts (attempted and successful) with either the primary care provider or the family. If after this month extension the care coordinator is not able to complete the contact with the client (telephonic or face-to-face), the client's case must be closed (totaling two months of unsuccessful contact with client) and the MICC provider must notify the primary care provider and the client via letter that the case will be closed. At this time, the care coordinator would send DMAS a copy of the completed Outcome Report (DMAS 53 or 54).

For infant clients, DMAS recommends that the care coordinator conduct a **face-to-face home visit** with the infant client within 30 days from the date of referral to the MICC program in order to complete an initial assessment of the home environment. For maternal clients, DMAS recommends that the care coordinator conduct a **face-to-face home visit** with the maternal client within the 90 days following the date of referral to the MICC, in order to complete an assessment of the home environment prior to the birth of the infant. If the care coordinator is unable to complete a home visit within these recommended time frames, there must be clear documentation why the home visit did not occur (i.e. the client or other member of the family refuses to allow the care coordinator in the home).

Admission Packet

DMAS no longer requires the MICC provider to submit the Service Plan (DMAS 52) as part of the admission packet. However, the client's medical record must have a completed Service Plan using either the DMAS 52 or the provider's version that is comparable to the DMAS 52.

The MICC forms have been revised (see forms section later in the document. The forms required for a MICC admission now include:

1. DMAS 55, Letter of Agreement (Also available in Spanish, DMAS 55-S);
2. DMAS 16, Maternity Risk Screen or DMAS 17, Infant Risk Screen; and
3. DMAS 50, Maternal and Infant Care Coordination Record.

Risk Screens

The Maternity and Infant Risk Screens have to be signed by a Medicaid provider approved to conduct screenings. (e.g., Physician, Nurse Practitioner or Certified Nurse Midwife). If the client's primary care provider is not the provider who signs off on the risk screen, the care coordinator should establish contact with the primary care provider to coordinate services.

The Risk Screen and the Maternal and Infant Care Coordination Record must have at least one risk identified on each form. The date that the initial contact was made should be indicated on the Maternal and Infant Care Coordination Record. This date will be used as the date that the MICC provider may begin billing for services. The admission packet must be completely filled out, legible and submitted within 45 days of the completion of the MICC assessment.

Upon receipt of the admission packet, the DMAS staff will notify the MICC provider via letter of the authorized begin date for MICC services.

The initial risk screen will be used for referral to the MICC Program. If the client is open to MICC, the care coordinator should provide ongoing risk assessment and document all risks (current and new) in the service plan and progress notes. The care coordinator need not complete additional risk screens unless the client requires re-enrollment in the MICC Program.

Closing a Client to MICC Services

MICC services are covered for the high-risk mother for up to sixty (60) days postpartum and the high risk infant up to age two. When the client is closed by the care coordinator, the DMAS 53 or 54 (Pregnancy or Infant Outcome Report) must be completed by the care coordinator and submitted to DMAS within 30 days of the case closure date. When the outcome report is received by DMAS, the MICC provider will be sent notification of the client's MICC Services closure date.

MILEAGE RATE INCREASE

Beginning with dates of service on or after July 1, 2006, the mileage reimbursement rate will be increased from $.22/mile to $.33/mile. MICC providers should begin to use the procedure code S0215 to bill for mileage for any client enrolled in MICC who receive services on or after July 1, 2006. If providers use the mileage code A0160 for dates of services July 1, 2006, or after, the lower rate of $.22/mile will be paid. This change will be reflected in an upcoming BabyCare Provider Manual update. Procedure code S0215 will pay only if care coordination (G9002) has paid for the same date range.

PATIENT EDUCATION CLASSES

This is a reminder that providers may bill DMAS for Patient Education Classes (S9446) on topics such as: health and nutrition, growth and development, safety (home and car) and others as listed in the BabyCare Manual, Appendix C. Topics must be related to a risk identified on the client's Risk Screen. Please note these classes are for pregnant women only. Providers who

wish to have programs approved for Medicaid reimbursement should forward the detailed course content, length of classes, and instructor certification to DMAS (see BabyCare Manual, Chapter 2 for details). Following DMAS' review of the program's content, a letter of approval/denial will be sent to the provider agency. A copy of this letter must be retained in the provider file. Providers must have a letter of approval to be reimbursed by DMAS for the classes.

MANAGED CARE ORGANIZATIONS

Medicaid Managed Care Organizations (MCOs) have their own high risk maternity and infant programs. Each MCO has established authorization and approval requirements for these programs. In addition, in order to provide services to managed care clients, providers must have a contract with the MCOs. Providers should contact the appropriate MCO about the requirements of their maternity and infant program.

Clients sometimes transfer between fee-for-service (FFS) and an MCO. DMAS providers who have already received an authorization for services should use the MICC Change Form (DMAS 56) to notify DMAS when a client becomes enrolled in the MCO. Likewise, in the event that a client is transferring from the MCO back to FFS MICC, the MICC provider must notify DMAS via the MICC Change Form (DMAS 56).

It is always the responsibility of the provider to verify the client's eligibility each time services are rendered to ensure that they have the appropriate authorizations, approvals, and contract requirements in order to bill for services (either FFS or the MCO).

DMAS MICC providers who do not have a contract with their client's chosen MCO should contact the MCO and assist in the transition of care to a network provider. In addition, the MICC provider must submit the closure information to DMAS via the DMAS 53 or 54 (Infant or Maternal Outcome Reports) within 30 days of closure. In cases where a client who was previously closed to MICC becomes eligible to receive MICC services, then the MICC provider must follow the guidelines for new enrollments as well as complete a new Risk Assessment.

FORMS

The latest versions of MICC forms are available on the DMAS website at www.dmas.virginia.gov, select "Maternal and Child Health", select "BabyCare" and then "Maternal and Infant Care Coordination (MICC) Forms." The latest version of the forms should be used. Submitted forms must be legible and complete. Any form that is incomplete (i.e. missing Medicaid number or provider number, no risk identified, no referral identified) will be returned to the provider to complete. Please note changes to the BabyCare forms DMAS-50, DMAS-55 and DMAS-56. There is also a Spanish version of the DMAS-50 now available.

All MICC forms that need submission to DMAS may be mailed to:

Department of Medical Assistance Services

BabyCare
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Or faxed to: 804-786-5799.

Please remember that claims (CMS-1500) are to be sent to:

Department of Medical Assistance Services
Post Office Box 27444
Richmond, Virginia 23261-7444

ELIGIBILITY AND CLAIMS STATUS INFORMATION

DMAS offers a web-based Internet option (ARS) to access information regarding Medicaid or FAMIS eligibility, claims status, check status, service limits, prior authorization, and pharmacy prescriber identification. The website address to use to enroll for access to this system is http://virginia.fhsc.com. The MediCall voice response system will provide the same information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

"HELPLINE"

The "HELPLINE" is available Monday through Friday from 8:30 a.m. to 4:30 p.m., except on state holidays, to answer questions. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid provider identification number available when you call.

All claims questions or concerns will be referred to the DMAS HELPLINE.

PROVIDER E-NEWSLETTER SIGN-UP

The intent of this electronic newsletter is to inform, communicate, and share important program information with providers. Covered topics will include upcoming changes in claims processing,

common problems with billing, new programs or changes in existing programs, and other information that may directly affect providers. If you would like to receive the electronic newsletter, please sign up at www.dmas.virginia.gov/pr-provider_newletter.asp.

Please note that the Provider E-Newsletter is not intended to take the place of Medicaid Memos, Medicaid Provider Manuals, or any other official correspondence from DMAS.

DMAS/FEE FOR SERVICE
BABYCARE TRANSITION CHART

ISSUE	CURRENT REQUIREMENTS	REQUIREMENTS AFTER JULY 1, 2006
Initial Contact for assessment and enrollment.	Initial contact is required within 10 calendar days and must be a home visit with referred pregnant mother or high risk infant and parent	• Initial contact may be collateral (telephone contact to referring provider, with family and/or client) and made within 15 calendar days. • The initial visit does not have to be a home visit. However if the client enrolls in DMAS BabyCare, a minimum of one home visit should be made within 90 calendar days for a maternity referral and a minimum of one home visit should be made within the 30 calendar days of an infant referral.
Face-to-face Contact	Initial contact is required within 10 calendar days and must be a face-to-face home visit.	Face-to-face contact (in any setting) must be completed within 30 calendar days from the receipt of the referral.
Extension for Visits	None. Client is only open to MICC and billable once face-to-face is completed and client agrees to be open to services.	• Providers may begin billing for reimbursement ($1.42/day for care coordination) from the date that collateral contact is made for attempts to engage client in services, for up to 60 days from date received referral. The collateral contacts include telephone or face-to-face contacts with primary care provider and family members, attempted home visits, etc). • If contact is not successful during the extension, the provider must notify the primary care provider and client via letter that their case will be closed. • Mileage is not reimbursable until a client face-to-face is completed.
Initial Contact Billing Requirement.	Client is considered open to MICC only once face-to-face contact is successful. Provider can not begin bill until client is open to MICC.	• Provider may bill for care coordination ($1.42/day) during the 'initial enrollment period', which may be up to 60 days from date of first collateral contact regarding the referral, whether or not the client decides to enroll in MICC. • Mileage is not reimbursable until a face-to-face is completed.

ISSUE	CURRENT REQUIREMENTS	REQUIREMENTS AFTER JULY 1, 2006
Refusal of enrollment	Providers may not bill for care coordination ($1.42/day) for attempts to engage client in services. If face-to-face visit is made and client refuses enrollment in program, provider can not bill for care coordination or mileage but may bill for assessment visit (G9001 = $25.00).	• Providers may bill for assessment visit (G9001 = $25.00) and the daily rate from the date the provider began attempts to engage client up to the client's refusal date (care coordination = $1.42/day) up to 60 days during the initial enrollment period. • Provider must notify the primary care provider via letter of client's/caregiver's refusal of enrollment into MICC.
Lost to follow up.	No guidance for providers on how long to attempt to engage a client for services. To bill for care coordination, must be face-to-face visit completed (minimum one per month).	• If client is open to MICC (one face-to-face minimum had been completed) and the provider is not able to make successful contact within a given month, the provider gets one month extension to connect with client (successful collateral or face-to-face contact). • If not successful in the extension month, the client must then be closed. Thus, with the extension, the provider may not have face-to face contact with the client for up to 60 calendar days but will have documented in the case record reasonable attempts to reach the client during the period. • Provider must notify the primary care provider and client via letter that their case will be closed.
Opportunity for providers to use professional judgment to determine the appropriate level of contact.	None. Manual dictates initial 10 day face to face home visit and then at least monthly face to face home visit required.	• Minimum one face-to-face needed to complete assessment (up to 30 days and then one extension). • Provider may determine level of contact needed post face-to-face assessment visit, depending on risk indicators. (Following more along guidelines for the MCO High risk maternity/infant programs).

ISSUE	CURRENT REQUIREMENTS	REQUIREMENTS AFTER JULY 1, 2006
Documentation Requirements	Admission packet: 1. DMAS 55 2. DMAS 16 or 17 3. DMAS 50 4. DMAS 52 Service Plan	• Admission Packet: 1. DMAS 55 2. DMAS 16 or 17 3. DMAS 50 • DMAS 52 or provider equivalent form must be kept in client medical record.
Mileage rate	$0.22/mile	$0.33/mile
Client transferring in and out of MCO to FFS	Not addressed.	• DMAS requires initial admission packet. • Notify DMAS BabyCare via BabyCare Change Form of transfers from FFS to MCO or vice versa.
Claim inquiries.	DMAS BabyCare Department would research claim inquiries via BabyCare Change form or other means of provider contacts.	• BabyCare Change Form will only be used for changes needed to MICC enrollment. • All claims inquiries will be referred to MediCall or HelpLine.
Spanish version of forms.	Not available.	Letter of agreement (DMAS 50) now available.